## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(For Disclosure to the Division of Health Care Financing and the Department of Workforce Services)

Client Name	Social Security #	Date of Birth
I		hereby authorize the
(Client or Personal Representative)		
(Person or Organization Disclosing	Information)	to disclose specific
health information from the records of the above nam Health Care Financing or the Department of Workfor		nt of Health, Division of
The specific health information authorized for disclos	sure is:	
The purpose of the disclosure is:		
I understand that this authorization will expire on the	following date, event, or condit	ion:
I understand that if I fail to specify an expiration date time needed to fulfill its purpose. I also understand the written notification to Privacy Officer indicated in the duplicate Notice of Privacy Practices can be provided understand that a revocation is not effective to the exploration of Workforce Services has relied on the organization.	hat I may revoke this authorization of Privacy Practices all lupon request when filling out the that the Division of Health	on at any time, by sending ready provided to the client (a his authorization). I
I understand that I may refuse to sign this authorization or the Department of Workforce Services controllment in a health plan, or eligibility for benefits	cannot deny or refuse to provide	treatment, payment,
I understand that, once information is disclosed pursu be protected by medical privacy laws and could be re		
By signing, I acknowledge I have been provided a co	py of this signed authorization.	
Signature of Client or Authorized Representative	/	
If signed by an Authorized Representative, a descript	ion of authority to serve:	

